

BP-A519_PSYCHOLOGY SERVICES INMATE QUESTIONNAIRE

PSYCHOLOGY SERVICES INMATE QUESTIONNAIRE

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

First Name		Last Name		Register Number	Date
Housing Unit		Case Manager			Date of Birth
Sex : <input type="radio"/> Male <input type="radio"/> Female		Race : <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> Asian <input type="radio"/> Hispanic <input type="radio"/> American Indian			
Marital Status : <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Common Law <input type="radio"/> Widowed					
Number of Children	Ages of Children		Highest Grade Completed in School		Main Occupation
Hometown/state/County			Have you Ever Served in the Military? <input type="radio"/> Yes <input type="radio"/> No		
Current Offense /Charges					
Sentence Length		Time Already Served on Sentence		Total Time in Jail and Prison During Life	
Have you ever received treatment for a nervous or Mental Problem ?			If yes, When?		
<input type="radio"/> Yes <input type="radio"/> No			If yes, Where?		
Have you ever taken or are you now taking any medication for a nervous or mental problem?			If yes, Where?		
<input type="radio"/> Yes <input type="radio"/> No			If yes, What Medication (s) ?		
Have you ever seriously considered Suicide?		Have you ever attempted Suicide?		Are you seriously considering Suicide Now?	
<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	
Have you ever committed a violent act such as an assault, rape, armed robbery, or murder ?				<input type="radio"/> Yes <input type="radio"/> No	
Have you ever received any incident reports for fighting or assault while you were locked up ?				<input type="radio"/> Yes <input type="radio"/> No	
Check any of the following you used in the two years before arrest:	<input type="checkbox"/> Amphetamine/Speed	<input type="checkbox"/> Tranquilizers/Valium	<input type="checkbox"/> Cocaine/crack		<input type="checkbox"/> Tobacco
	<input type="checkbox"/> Glue/Solvent/Inhalants	<input type="checkbox"/> Heroin/Morphine	<input type="checkbox"/> PCP		<input type="checkbox"/> Alcohol
	<input type="checkbox"/> Sleeping Pills/sedatives	<input type="checkbox"/> LSD/ Psychedelics	<input type="checkbox"/> Marijuana		<input type="checkbox"/> Other
Have you ever experienced a serious head injury?		If yes, where you unconscious		Have you ever experienced a seizure?	
<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No		<input type="radio"/> Yes <input type="radio"/> No	
Do you have any serious medical conditions or concerns at this time					
<input type="radio"/> Yes <input type="radio"/> No					
If yes, describe briefly:					
Check any of the following which you have experienced during the last 2 weeks ?	<input type="checkbox"/> Nervousness/Tension	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Feeling Hopeless	<input type="checkbox"/> Other, Describe	
	<input type="checkbox"/> Depression	<input type="checkbox"/> Racing Thoughts	<input type="checkbox"/> Concentration Problems		
	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Relationship Problems	<input type="checkbox"/> Severe Headaches		
	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Hallucinations		
Do you desire psychological services at this time? <input type="radio"/> Yes <input type="radio"/> No					
Signature					Date